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ABSTRACT

Low rates of service to older persons in community mental health programs were investigated in 20 California county government sponsored programs. County administrative officers, mental health advisory board members, directors, clinic supervisors, and clinical staff were surveyed through a mailed questionnaire. Levels of awareness of problems of the older population, familiarity with relevant government policy, perception of the community's priority for elders, and personal priority for elderly and attitude toward them were explored. The study controlled for urban/rural locale and for the availability of alternate services. Results indicated that perception of communities' priorities for providing service was significant. Awareness of problems of elders and of relevant governmental policies, especially federal, was generally low. Attitude toward aged was highly positive among all respondents but, in contrast, personal priority for service to elders was lowest. Among policy formers, directors and advisory board members tended to be more important in developing services to elders. (Author)

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COMMUNITY MENTAL HEALTH CARE OF THE ELDERLY: POLICY MAKING AND IMPLEMENTATION

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SUMMARY

Low rates of service to elders in mental health programs were explored in twenty California counties. Administrative officers, advisory and staff were assessed for levels of awareness of problems of the older population, familiarity with relevant government policy, personal priority and attitude toward aged. The study controlled for urban/rural locale and for the availability of alternate services.

A community's sense of priority was found to be a significant factor in effecting service to elders. Awareness of problems of elders and of relevant governmental policies, especially federal, was generally low. Attitude toward aged was found highly positive but, in contrast, personal priority for service was extremely low. Directors and advisory board members tended to be major influencers in developing services to elders.

Findings were supportive of group and elite models of social policy theory and of a social action approach to developing programs for elderly.

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This paper reports the findings of a study undertaken in 1975 to explore the observation that the older population was grossly underserved in the California community mental health system. It was postulated that low rates of service might be related to certain characteristics of clinical staff, program supervisors, program directors, advisory board members, and county administrative officers. . . designated as "policy actors" in this report. Also, based on several models of social policy theory--notably the institutional model (Weber, 1947), the group

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model (Truman, 1951), the elite model (Dye and Zeigler, 1970), the rational decision-making model (Katz and Kahn, 1962), and the systems model (Baker and Schulberg, 1965)--seven characteristics of the mental health system and its policy actors were explored (see Fig. 1). The first five were characteristics of the policy actors themselves: (1) knowledge of the problems of elders, (2) knowledge of government policy relating to the aged, (3) perception of the community's priority for service to elders, (4) personal priorities for service to elders, and (5) personal attitude towards the aged. Two other characteristics were environmental factors construed as control variables in the study: (6) location of the mental health service in an urban or rural area, and (7) the availability of other mental health or gerontological services in the county which could affect service rates.

The context for the study was the California community mental health service system, a network of fifty-eight community mental health programs administered by the local county governments. The focus was on the outpatient services provided in a one-year period in twenty of these programs--the ten providing the highest rates of service to elders for that year, and ten providing the lowest rates of

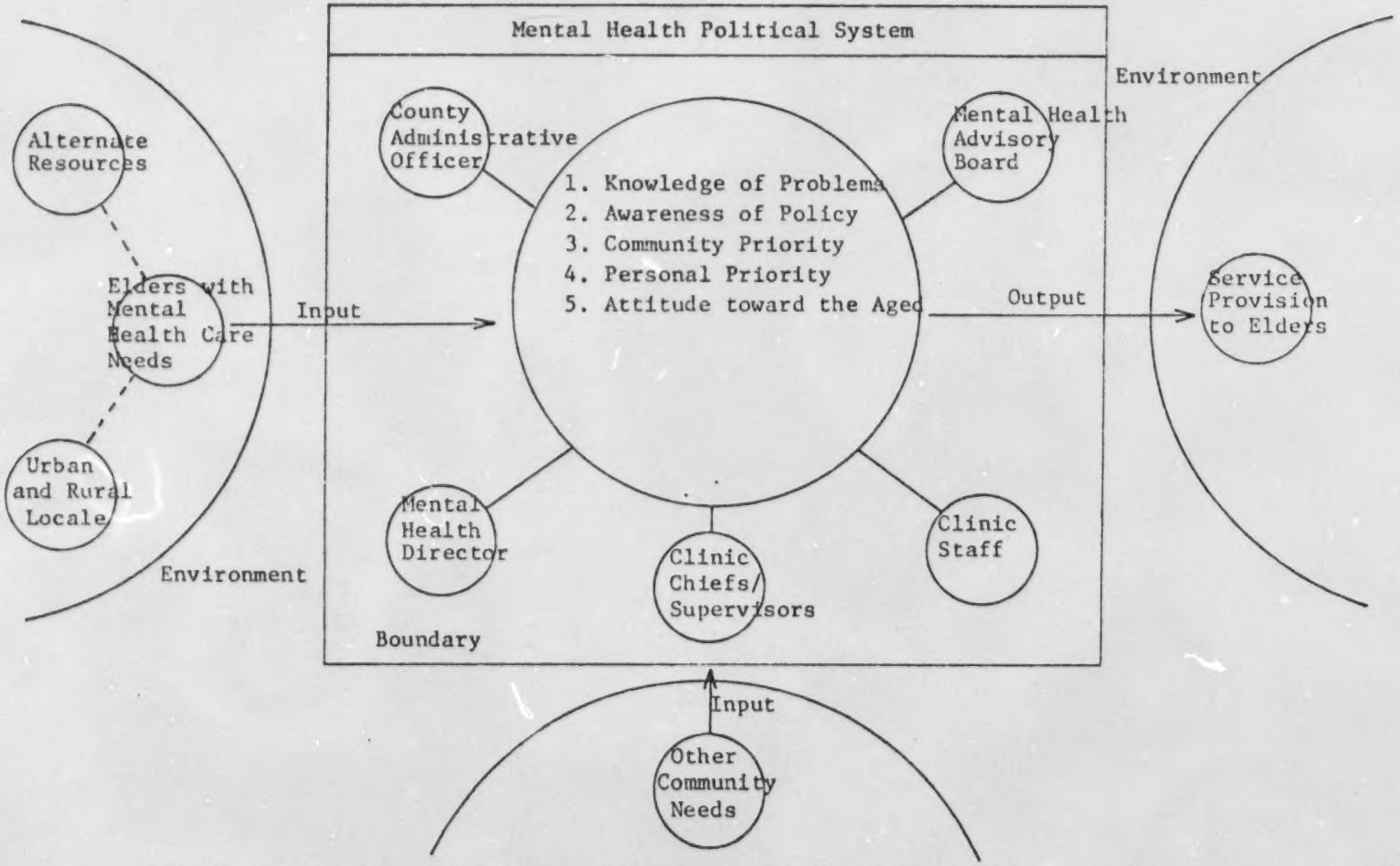

Fig. 1. Factors in the Delivery of Mental Health Services to Elders. A Systems Theory-Based Model. (Adapted from Wilbur A. Finch, Jr., Bruce C. Jannson, and Samuel H. Taylor, "New Approaches for Preparing Social Work Practitioners for Participation in Organizational and Community Change" (unpublished Monograph, University of Southern California, 1977).

service. A mailed questionnaire was sent to each of the 636 individuals in the policy actor group. Completed questionnaires were returned by 398 respondents (62.5 percent). A follow-up telephone survey was conducted with the geriatric coordinators in each of the twenty counties surveyed in order to provide a source of external information in relation to the accuracy or validity of the findings derived from the mailed questionnaire.

Major Findings

Regarding knowledge of the problems of elders, almost all of the policy actors appeared to be poorly informed about the number of elders in the general population, the rate of mental disorder among elderly people, and the number in institutions. Despite this generally low-level of awareness, the administrative officers, advisory board members, and the directors from the higher-serving programs were significantly more aware of the problems of elders than their counterparts in lower-serving programs. This finding was at least marginally supportive of one principle of rational planning theory--that cognitive awareness precedes action.

Knowledge of governmental policy was not found to

relate to the rate of service. Policy actors showed high levels of awareness of state and local government policy but, as a group, appeared to be particularly unaware of many provisions of the Older Americans Act. In regard to awareness of federal policy, clinical staff, administrative officers, and program chiefs correlated negatively with the rate of service. Those who were most familiar with federal policy were located in lower serving programs. This tended to contradict the contention of rational planning theory that cognitive awareness precedes action.

Perception of community priority for elders was found to be one characteristic which did differentiate higher and lower rates of service. On a six-point scale, the higher-serving programs gave fifth priority to elders, whereas the low-serving ones gave them last (sixth) priority. While the difference between a fifth and sixth ranking is certainly modest, and not worthy of a sense of satisfaction or confidence in the validity of the ranking, it is interesting to note that these differences are attributable in large part to responses derived from advisory board members and clinical staffs of the higher-serving programs. These two categories of respondents tended to give higher priority to elders than their

counterparts in lower-serving programs.

Personal priority for service to elders was not found to significantly relate to the rate of service; all policy actors gave elders their lowest personal priority. Personal priorities for service appeared to be positively correlated with youth, except for preschool children. Despite this generally negative finding, a tendency for advisory board members and clinical staff from higher-serving programs to report a somewhat higher personal priority for elders was indicated.

In contrast to the above findings, personal attitude toward the aged was found to be highly positive among almost all of the respondents. No significant differences were found that could be related to the rate of service. However, advisory board members associated with higher serving programs were felt to be more positively oriented toward the elderly than their counterparts from lower-serving programs.

The five characteristics of policy actors discussed above were controlled in this study by two environmental factors: urban/rural location and the availability of alternate resources.

Urban or rural locale was not found to be a factor

influencing the rate of service, although blurred definitional distinctions regarding what is a rural or urban environment leave this finding open to question.

Availability of alternate community resources for the elderly was found to be low in all the counties studied, and not significantly different among higher- or lower-serving counties.

The follow-up exploration with the geriatric coordinators essentially validated the findings of the mailed questionnaire. The post-study survey also confirmed that the advisory board members and the program directors tended to have more influence in developing services to the aged than other policy actors. Suggestions for other possible areas of inquiry offered by the geriatric coordinators were (1) whether the adult education and general public health education efforts on the availability of mental health facilities increased their use by elders, (2) whether the terms "mental health" and "psychiatric" actually decrease the use of these services by elders, and (3) whether the location of a mental health service in a nonmedical setting improved utilization of service by the elderly.

Knowledge of the Problem

Respondents' knowledge or awareness of the problems of elders was explored in three specific inquiries about demography and epidemiology related to the aged. The general research questions were:

> Is the aggregate degree of awareness of elders' problems among actors in community mental health systems related to the rate of service provided to elders?
>
> Is the degree of awareness of the problems of elders by specific policy actor groups related to the rate of service?

Regarding knowledge of the problem, it was expected that there would be no difference between the collective scores of respondents from programs providing a high rate of service and the collective scores of respondents from low-serving programs. A second expectation regarding knowledge of the problem was that there would be no difference in the scores of specific policy actor groups from higher-serving programs and the scores of their counterparts in lower-serving programs.

The first finding was that, viewed collectively, there were no significant differences between the test scores of the higher-serving policy actors and the scores of policy actors from low-serving programs. The major

finding was a generally low level of awareness of the problems of elders among all those responding.

The study sought to determine if there were significant differences which might affect the rate of service but which were obscured in the gross measure of collective scores. Analysis of the data resulted in the finding that there were no significant differences between specific policy actor groups from high-serving programs and their counterparts in low-serving programs. However, based on individual item analysis, some trends in the data were observed: the administrative officers, advisory board members, and directors from higher serving programs were significantly more knowledgeable about demography and epidemiology than their lower-serving counterparts.

An inference that can be drawn from this is that the responses of three policy actor groups to this inquiry offers marginal support for elements of the rational planning model of policy theory--notably that cognitive awareness precedes action.

Awareness of Policy

Awareness of governmental policy was tested in eighteen questions which assessed respondents' familiarity

with fifteen federal, one state, and two county government policies related to the aged. The research questions explored were:

> Is the degree of awareness of governmental policies on the aged by actors in the community mental health system related to rate of service?
>
> Is the degree of awareness of governmental policies by specific policy actor groups in the mental health system related to the rate of service?

One expectation was that there would be no difference between the collective degrees of familiarity of respondents from high-serving programs and collective degrees of familiarity of respondents from low-serving programs. The second expectation was that there would be no significant difference between the degrees of awareness of specific policy actor groups from high-serving programs and their counterparts in lower-serving programs.

The study found no significant correlation between levels of policy familiarity and rates of service. However, when federal, state, and local policy familiarity or awareness were evaluated separately, awareness of federal policy by lower-serving programs was found to be significantly higher. It was speculated that lower-serving programs, by virtue of their not providing much service themselves, relied more heavily on the more direct

service-oriented federal programs and hence knew more about them.

On the second question, regarding familiarity with policy by specific policy actor groups, the policy actors who contributed to the difference in awareness of federal policy were identified. The county administrative officers, the program chiefs, and the clinic staffs from the lower-serving programs all reported a significantly higher level of familiarity than their counterparts in high-serving programs. The advisory board members were ranked at approximately equal levels. Only the program directors' responses supported the contention of the rational planning model that a higher level of awareness would be related to a higher rate of service.

Familiarity with state and local government policy was not found to relate significantly to the rate of service. All policy actors indicated a high level of familiarity with both of these policy areas. In contrast, the level of familiarity with federal policy was not very high among the respondents. Indeed, many important federal programs--especially those derived from the Older Americans Act--were only vaguely familiar to most of the policy actors.

A most important finding was the generally low level of policy familiarity displayed by all of the policy actors. If this finding is considered along with their low level of awareness of the problems of elders, one can speculate about why the aged are so poorly served in the mental health system.

Even if the mental health sytem policy actors were better aware of the dimensions of the problems of elders, their general unawareness of current policy and programs and their related resources would dampen any efforts they might make to provide service to the elderly.

Perception of Community Priority for Elders

Perception of the community's priority of service to elders was explored to estimate the extent to which the rates of service might be in response to community pressure. This was, to some extent, a test of some of the elements of the group and elite models of policy theory.

These theories suggest that a higher rate of service would be (in the elite model) the result of influence by the community elite on those implementing policy or (in the group model) the result of pressures from organized groups in the community.

The measure utilized to test this characteristic was the priority level given by policy actors to providing services to elders when forced to rank priorities among six age groups for mental health service. The research questions posed in this issue were:

> Is the level of the community's priority for service to elders, as perceived by actors in the community mental health system, related to the rate of service?
>
> Is the level of the community's priority for service to elders, as perceived by specific policy actor groups in the community mental health system, related to the rate of service?

The first expectation based in the research design, was that the community's priority for service to elders, as perceived by respondents in higher-serving programs, would not differ from the priority perceived by those in lower-serving programs. The second expectation was that there would be no difference in the priorities assigned by policy actor groups from higher-serving programs and the priorities reported by their counterparts in lower-serving programs.

Significant differences were found in both areas explored. Higher-serving programs perceived elders as fifth in priority for service in their communities. Lower-serving programs perceived elders as lowest (sixth) in

their communities. Though the performance of both groups was discouraging in terms of qualitative assessment, the difference was statistically significant.

While neither group were of the opinion that their communities had great enthusiasm for providing service to elders, the finding did lend some support to the contention of group and/or elite models of policy theory. If policy implementation is the outcome of community group or community power elite influences on the service providers, then the policy actors must perceive these influences in their communities.

Further support for this contention was found in the views of specific policy actor groups. Significant differences were found between two of the policy actor groups. Advisory board members and clinical staff from higher-serving programs were of the opinion that their communities' priority for service to the aged was at a significantly higher level than their counterparts in lower-serving programs. Of note in regard to this finding is that, of the five policy actor groups, the advisory board members tended (on the basis of their responses on the first three characteristics) to be an increasingly important factor in relation to the rate of service.

While their levels of differences were not significantly different than other policy actor groups, they consistently showed a relationship to awareness of problem and policy and perception of community priority. Those from higher-serving programs generally scored higher than advisory board members from lower-serving programs.

Personal Priority for Service to Elders

The personal priority of respondents for providing service to elders had been estimated to be a potentially powerful discriminator between higher- and lower-serving programs. On face value, it would appear reasonable to expect that sentiment favoring work with a population group would very likely result in a higher rate of service to that group. While the research question postulated that no difference would be manifested, the expectation was that a higher priority could be found in higher-serving programs. The research questions used to explore the relationship of personal priority toward the aged and rate of service were:

> Is the level of personal priority for service to elders, as held by the community mental health system, related to the rate of service?
>
> Is the level of personal priority for service to elders, as held by specific policy actor groups, related to the rate of service?

[14]

To measure the level of priority, policy actors were asked to rank six age groups in terms of their priority for receiving mental health services.

The findings from this exploration were that there were no significant differences reported (between high- and low-serving programs) in terms of respondents' personal priority for service to elders. There also were no significant differences among any of the policy actor groups, although there was a tendency for advisory board members and clinical staff from higher-serving programs to report a higher level of personal priority toward the elderly. All policy actor groups, however, clearly placed elders lowest (sixth) in personal priority. Of note is that personal priority was positively correlated with youth, except for preschool children (who rated second lowest). This finding tends to confirm a view generally held, namely, that the mental health professionals have little interest in working with the very young and the very old.

Attitude toward the Aged

Even more than personal priority for the aged, a positive attitude toward the aged by policy actors was expected to be related to a higher rate of service. To

explore the potential for this effect, two research questions were posed:

> Is the attitude toward the aged as held by community mental health programs related to the rate of service provided to elders?
>
> Is the attitude toward the aged as held by specific policy actor groups related to the rate of service?

The research questions were tested by comparing attitude scale scores of policy actors from higher serving programs with scores of those from lower-serving programs.

The findings were not only that there were no significant differences between high- and low-serving programs, but almost all respondents scored as highly positive in their attitude toward the aged.

The findings relating to the second question showed that there was no significant difference between specific policy actor groups; all were highly positively oriented toward the elderly. There was a tendency for the higher serving advisory board members to show slightly more positive attitudes than their lower serving counterparts. This last finding, coupled with the trends noted on other characteristics, leads the author to conclude that advisory board members are a likely source of influence if a campaign is to be launched to increase rates of service to elders. Although the evidence is not strong, the

characteristics of the advisory board members toward the aged were more often correlated or nearly correlated with the rate of service than was the case in any other group of policy actors.

In the matter of respondents' attitude toward aging, it seems paradoxical to find such positive scores in the same context with low service priorities, limited awareness of policies, and low level of awareness of the problems elders are faced with in this society. The findings in this study are also contrary to those of most other studies which reported negative attitudes of health personnel toward the aged. Barring an inadequate instrument, a biased sample, or the halo effect of an inquiry such as this, the study suggests the mental health system may be more favorably inclined toward the aged than previously thought. That it does not see elders as candidates for service in the mental health system may well be the result of other factors--such as the community's demand that these services be given to other population groups.

Faced with insufficient resources to meet all the demands, policy actors in the mental health system very well may shelve their personal feelings and provide service to those groups equally worthy, but either more assertive

in securing service or held as of greater worth or importance in the community.

Influence of Urban and Rural Locale

The literature on delivery of health services frequently makes reference to urban and rural differences--in quantity and quality of services, in accessibility, and in the use of family and other nonpublic services. Although the distinction between the concepts of urban and rural is generally considered difficult to operationalize, this study made an effort to assess the relationship between locale and the characteristics of the policy actors. To assess this relationship, half the programs selected for the sample were urban and half rural; observations were made on differences between the two groupings and the policy actors within them. The research questions explored in this context were:

> To what extent does location of a community mental health system in an urban or rural area relate to characteristics explored in this study?
>
> When differences between programs are found, is there any relationship to locale?
>
> When differences between policy actors are found, is there any relationship to locale?

Regarding the first question, the study produced the finding of no significant relationship between

locale in urban and rural areas and the five characteristics studied.

When differences were found between higher- and lower-serving programs, analysis of the data indicated that locale tended to be associated with two of them. A higher awareness of problems of elders was found in urban locales and a greater level of awareness of federal policy was found in rural locales. Exploration of urban versus rural differences showed no relation to the other three characteristics studied: community priority, personal priority, and attitude. The marginal level of difference found on awareness of problems and policies shows some tendency for these two characteristics to vary by locale, but no firm conclusions can be drawn from these data.

From these findings it can be inferred that the policy actor responses were fairly constant in both urban and rural locales, and that dimension does not, by itself, influence the rate of service to the older population.

The limitations on resources for data analysis did not permit a thorough study of the differences between characteristics of specific policy actor groups and their locales. The few areas where differences were observed seemed to indicate that a more extensive probe with more

distinct urban and rural samples might better determine whether locale is a significant factor in the delivery of mental health service to elders.

Availability of Alternate Resources

To explore whether the presence of other psychological and physical support services would either detract from or stimulate use of community mental health services, two questions were explored in the study:

> To what extent does availability of other resources correlate with the characteristics explored?
>
> Is there any evidence that availability of alternate services is related to differences found between programs or policy actors?

The major finding (based on policy actor estimates) was that availability of resources was consistently low in the areas explored. No correlation was found between availability of resources and the policy actor or program characteristics studied. Indeed, the general estimates of availability of resources were remarkably similar in program and policy actor groups--whether high- or low-serving, urban or rural. The conclusion drawn was that the presence or absence of alternate resources in the community neither increased nor decreased the use of mental health services by the older population.

Follow-up Exploration

To obtain a measure of external validity for the questionnaire and the resultant findings, twenty geriatric coordinators from each of the counties surveyed were interviewed. Estimates of policy actor influence, availability of alternate services, and adequacy of service to elders were the areas explored. This follow-up survey generally supported the validity of the findings derived from the mailed questionnaire. Especially noteworthy is the confirmation of a trend: the advisory board members and the directors seem to have a major influence on what little is being done for elders in the mental health system. A generally low level of interest in elders was also confirmed, as well as a pervasive sentiment that elders were being underserved. Reasons most often proposed for low levels of service were: (1) the lack of interested staff, and (2) the reluctance of elders to seek help for problems labeled "mental." Similarly, the number of other resources was generally confirmed as few in number and, more often than not, tangential to the mental health care needs of elders.

Major Conclusions

Several firm conclusions can be drawn based on the mailed questionnaire and the follow-up exploration. One can conclude that the mental health community knows little about the problems of older persons and is only slightly aware of pertinent government programs and policies. It is clear that people active in the mental health system do not feel that the elderly are given a high service priority by the general community. On a personal level, the policy actors in the mental health system do not place a high personal priority on service to elders. Despite these negative findings, the mental health community reports a highly positive personal attitude toward the aged. In other words, older people are nice folks as long as one does not have to work with them.

The research also provided data supporting the argument that some policy actor groups can influence higher rates of service to elders. The responses of advisory board members and the program directors exhibited a tendency to be associated with the rate of service more frequently than other policy actor groups.

Neither urban versus rural location nor the availability of alternate resources were found to significantly

affect the five characteristics explored. Neither was found to correlate with higher or lower rates of service to elders. This finding lent some support to the contention of the group model of policy theory that the mental health system responded to community demands--be they in urban or rural locales of in communities with other services for elders.

In summary, the most significant findings were that there was a very low level of knowledge about the problems of elders, or awareness of government policies and programs for elders, or personal priority for serving elders. Except for the finding of a generally positive attitude toward the aged, the mental health system seemes to exhibit very little inclination to serve the older person. There is little concern for elders as evidenced by findings on knowledge of their problems and related policies and programs designed to help; there is a general disinclination to work with elders as evidenced by the level of personal priority for service to older persons. Respondents' positive attitudes toward the aged may be an anomaly caused by the test instrument used in this study or limitations of the simple. It is conceivable, however, that the ostensibly paradoxical views of low priority and a highly

positive attitude are not actually in conflict. It is conceivable that there may actually be a genuine interest in elders within the mental health system. However, to translate this into action there must be a greater demand by the community for service to its elderly citizens.

Lest the advocates of the rational planning model of policy theory lose faith, analysis of the data when structured to examine responses of specific policy actor groups produced one interesting trend. Although the differences among policy actor groups were seldom significant, the policy actors from the higher serving programs generally obtained somewhat higher (albeit still low) scores than actors from lower-serving programs. On twenty-seven items, the higher-serving actors scored higher; on nineteen, the lower-serving scored higher; and twelve items were tied (see Appendix 5-a).

There is additional support in this finding for the rational planning model of policy theory. The frequency of significantly higher test scores by high-serving advisory board members and directors identifies these groups as positively related to a higher rate of service to elders. It suggests that higher levels of knowledge and awareness

of problems, policies and programs is likely to result in a higher rate of service.

Implications of Findings

The expectation was that some of the characteristics studied in this research might lead to an explanation of the low rate of service provided to older persons. Except for the finding regarding community priority for service to the elderly, the expectations of this study were not realized. What the study did provide was a great deal of information about the mental health system, particularly about persons in the system who were thought to influence the delivery of service. In addition, some trends and tendencies in the findings lead one to speculation about possible directions for program development in geriatrics, for the practice of social work (particularly community organization), for mental health center administration, and for research in policy implementation.

Implications for Social Policy Research

In basic research, negative findings are generally considered as important as positive, in that they at least inform researchers about what is not, if not what is. For

social policy research, the question of who really makes decisions is narrowed by the findings of the study. Policy decision making can be likened to a great river which draws from its many tributaries, the innumerable component premises, which constitute it. The assumption in this study was that the decision to serve or not serve the elderly was based with those decision-makers in the community mental health system who presumably had the power to influence change in the system. Indeed, this study indicated that at least two of the policy actor groups--the advisory board members and the directors--actually did influence policy. Another implication from the study is that the systems model utilized to identify factors involved in policy implementation is a useful one. While the characteristics thought to be important in decision-making were not confirmed, there is opportunity within the model to explore other factors that impinge on policy implementation. Of the several theoretical models considered in this study, the group model was probably the most clearly supported; the implication from this finding is that community group pressures appear to have more to do with mental health implementation than rational planning or the orderly bureaucratic process of the institutional

model. The role of the community elite in influencing policy decisions was neither supported nor discounted in this study; there was some evidence that either the group model or the elite model could account for decision-making in the community mental health system. If this contention were to be supported by further investigations, the implication is that policy implementation would most likely occur more effectively when the community power elite were influenced, or when "countervailing forces" were activated in the community.

Implications for Social Work Practice, Specifically Community Organization

The implications from this study for social work practice are perhaps self-evident. If indeed social change is more often the result of power elite influence or community group pressure, then the message to the community organizer is clear: social action and assertive community development are the approaches of choice. The community planning model of community organization based in a rational planning approach, finds less support in this study. The rational planning approach seems less a factor in producing community program change than engaging in community power politics. Thus, the community organizer

could best influence development of services for elders by either helping older persons to organize and make demands for services or by attempting to influence the community power elite to allocate resources for service to this population. Of course, neither approach is mutually exclusive and neither discounts the importance of a rational planning approach in policy development or the development of community organization strategy.

For the social work educator, the finding that mental health personnel are not well informed about the problems of older persons or of pertinent social policies is of significance. A fairly large number of social workers were part of the sample and were as unaware as their colleagues of the scope and quality of the problems of older persons. They were also relatively uninformed about social programs which might be utilized to provide service. What appears necessary is some form of some affirmative education approach aimed at members of the community mental health system to inform them of the problem, of available service models, and of intervention techniques.

Implications for Mental Health Administration

In the idealized model of a mental health center or community mental health program, all those within a given geographical areas who need, want, or could effectively use helping services, would receive them as quickly as possible --with as little disruption to their lives as possible. The intervention services would restore them to effective functioning as quickly as possible and they would return to their roles in society. Among the problems in implementing this concept are the mental health system's difficulty in identifying its "proper" clientele, in developing needed economic resources and in providing the services that would indeed restore the elderly to effective functioning. What constitutes appropriate rate of service to the older population is therefore somewhat elusive. This study indicates a low priority for provision of mental health service to the older population, yet an affirmative action approach featuring a quota system might change this. Indeed a similar idea is currently a part of current (1977) federal government planning in relation to community mental health center funding. A quota of 20 percent of all services to the 65-and-older population is being discussed

as a goal for community mental health service programs.

In his role as the allocator of resources, the administrator has the task of finding resources to meet the needs of a population group before he can encourage them to use services. With the low number of mental health resources for elders in existence at the present time, a mental health director could not encourage service to this population unless he had unused resources or the capability of developing new ones. Even if the directors and administrators were more aware of existing resources than are indicated in this study, they would still not be able to fund a new program. What is clearly needed is some better method for funding mental health services for the elderly either through changes in Medicare legislation or through the development of a new, specially earmarked fund at the state level.

The county administrators' low level of awareness of the Older Americans Act provisions suggests that this legislation is an unused resource. In some counties this legislation has facilitated use of nutrition programs for the provision of mental health services and facilitated hiring of older staff to raise the range and quality of services to older persons. But, this program's potential

application for mental health services seems virtually unknown to administrators. Further, administrators could also use the newly developing continuing education requirement for relicensure in many helping professions to promote more effective services to the aged. If not the administrators, surely the federal and/or state funding agencies could promote the training of personnel in geriatrics by making it a requirement for granting of public funds.

The role of the mental health advisory board was a surprising finding in this study. Administrators generally do not utilize these boards to full potential. Yet, based on findings in this study the administrator who wished to develop a meaningful geriatric service might indeed seek the involvement of his advisory board.

Another implication for administrators is in the degree of emphasis to be placed on training clinical staff in working with older persons. While it is probably important to have them acquire techniques for working with older persons, their role in policy development is much weaker than generally thought. It seems more desirable to focus training efforts on other policy actors in the mental health system in order to produce change or improve services.

Implications for Future Research

Some of the paradoxical or contradictory findings of this study warrant further investigation. The finding of highly positive attitudes toward the aged, combined with extremely low priority of service to them, is particularly perplexing. Is it indeed possible for the mental health system to be positively inclined to a population group and still not provide service to them? Worthy of exploration is the process in which policy actors who favor elders decide to allocate resources to other population groups. The positive correlation of rate of service and perception of community priority suggests that factors in the community are at work which influence the policy actors. This observation warrants further exploration to determine if particular individuals or groups within the community influence these changes and to explore the relative validity of elite and group models of policy theory.

The sophisticated perspective of the older person toward the use of mental health services was noted by several geriatric coordinators as a possible reason for low utilization rates. At this point in time, studies exist on the attitudes of older persons toward mental disorder, but little is known about their attitudes toward mental health

care providers and their facilities. Whether the terms "mental health" or "psychiatric" indeed influence the older person to refuse service, or whether the location of a mental health service in a medical setting affects the willingness of the older population to seek help with emotional problems warrants further study.

Why the very young and the very old are given the two lowest priorities is another finding requiring exploration. Whether this is related to personal traits of the personnel in the mental health system, or whether it is an unconscious response to cultural or social attitudes is not clearly known. Speculation has been that mental health workers have a sense of discomfort when working with older persons, and see them as less worthy than other members of the community. The low priority to children raises the question of whether the same or similar dynamics apply with this age group. Comparison of attitudes toward both age groups may help unravel the issue.

The finding that lower-serving program members tended to be more aware of federal policy than the higher-serving ones contradicts a basic premise of the rational planning model. That lower-serving programs, especially those in rural areas, are more aware of federal programs

suggests that communication linkages between federal government and certain types of communities is qualitatively different. Whether increased awareness of federal programs, and possible reliance on them in some way, limits the growth of local services is a speculation worth further consideration. This factor combined with the views of some elders that mental health centers are not acceptable treatment locales suggests that the neighborhood health center as it has grown under federal auspices may be a first step in the direction of improving availability of services to elders.

The positive attitude toward the aged found in most policy actors may augur for better service to elders. It suggests that a crack in the barrier between mental health professionals and the elderly does exist. Even if it is based in enlightened self interest of the aging mental health professional, there is increasing likelihood that those in the mental health programs of the near future may be more open to serving the older population.

To conclude, it appears that the rate of service to elders in the community mental health systems is the by-product of multiple factors. The implication of this study is that determining policy implementation requires

constant and consistent awareness of the many influences on those supplying services and those who would receive them. A parochial view of cause and effect would lend us to hasty, simplistic policy decisions. Consistent analysis of the mental health system, assessment of program capabilities and target population needs, testing of new programs--are all required to provide for optimum utilization of mental health resources and optimum levels of mental health for the elderly.

APPENDIX

QUESTIONNAIRE DATA AND STATISTICAL ANALYSES

a. Summary of Findings

b. Kruskal-Wallis Analysis of Variance

c. SPSS ANOVA

d. Tables

e. Questionnaire

f. Bibliography

APPENDIX -a

QUESTIONNAIRE SCORES OF POLICY ACTORS ON THE FIVE TEST CHARACTERISTICS GROUPED BY HIGH- AND LOW-SERVING PROGRAMS

Characteristic	County Admin. Officer	Mental Health Advisory Board	Mental Health Director	Program Chief	Clinical Staff	Totals
			High-Serving Programs			
Knowledge of Problems of Elders (% correct)						
Question 1	45.4	22.0	0	36.8	23.7	26.5
Question 2	33.3	25.4	40.0	36.8	29.6	27.7
Question 3	40.0	35.6	100.0	26.3	30.4	32.8
Total	37.5	27.7	46.6	33.3	27.9	29.0
Awareness of Policy						
Federal	2.13	2.58	3.17	2.77	2.36	2.46
State	3.86	4.24	5.00	4.44	4.06	4.26
Local	3.84	4.05	4.60	4.43	3.83	3.95
Total						2.83
Community Priority						
Median	5.00	4.68	4.75	5.12	4.78	4.78
Mean						4.58
Personal Priority						
Mean	4.40	4.53	5.00	4.24	4.23	
Median	5.0	4.6	5.0	4.6	4.3	4.77
Attitude toward the aged						
Mean	8.27	- -	5.40	7.08	7.97	7.67

APPENDIX a--Continued

Characteristic	County Admin. Officer	Mental Health Advisory Board	Mental Health Director	Program Chief	Clinical Staff	Totals
			Low-Serving Programs			
Knowledge of Problems of Elders (% correct)						
Question 1	0	24.5	33.3	20.0	31.4	21.8
Question 2	25.0	28.6	16.6	40.0	25.9	27.2
Question 3	28.6	14.6	33.3	40.0	27.8	28.8
Total	17.4	22.6	27.8	33.3	28.4	25.9
Awareness of Policy						
Federal	2.85	2.61	2.68	2.59	2.60	2.6
State	4.00	4.12	4.94	4.43	3.80	4.2
Local	3.62	3.99	4.50	4.24	3.72	3.9
Total						2.8
Community Priority						
Median	5.00	5.11	4.50	4.50	5.19	5.0
Mean						4.8
Personal Priority						
Mean	4.12	4.63	3.80	4.69	4.30	
Median	5.5	4.8	4.0	5.6	4.6	4.7
Attitude toward the aged						
Mean	7.62	7.94	5.67	5.67	7.39	7.3

APPENDIX b

KRUSKAL-WALLIS ONE WAY ANALYSIS OF VARIANCE
FOUR WAY DIFFERENCES
(HIGH-LOW-URBAN-RURAL)

Variable	KW Test Stat.	Level of Significance[1]
Knowledge of Problems		
1. Elders in Population	8.18064	0.0424
2. Elders in Institutions	1.54571	0.6715
3. Prevalence of Mental Disorder	9.76214	0.0206
Knowledge of Policy		
4. Homemaker Service	0.92127	0.8203
5. Employment Service	2.06658	0.5587
6. Meals on Wheels	4.03337	0.2579
7. RSVP	4.69479	0.1956
8. Senior Companions	1.78201	0.6159
9. Foster Grandparents	5.10376	0.1641
10. Medicare	4.98275	0.1731
11. Medi-cal	3.30327	0.3472
12. Social Security	2.50800	0.4738
13. S.S.I.	6.86987	0.0762
14. Gold Card	2.45321	0.4838
15. Information & Referral	4.55058	0.2078
16. Tax Exemption	8.80878	0.0319
17. Law Project	11.08966	0.0113
18. Admin. on Aging	6.72740	0.0790
19. County Policy	0.40247	0.9397
20. County Policy	0.94654	0.8142
21. State Policy	1.50418	0.6813
Personal Priorities		
22. Pre-School	2.29580	0.5139
23. School Age	1.87541	0.5987
24. Adolescents	13.53198	0.0036
25. Young Adults	5.96517	0.1133
26. Mature Adults	1.93299	0.5864
27. Elders	4.67501	0.1972
County Priorities		
28. Pre-School	5.65175	0.1295
29. School Age	2.11308	0.5493
30. Adolescents	12.38043	0.0062
31. Young Adults	9.23591	0.0251
32. Adults	8.45953	0.0374
33. Elders	3.89955	0.2725
Alternate Resources		
35. Psychological	2.51773	0.4721
36. Physical	1.92913	0.5872
Attitude Toward Aged		
39. Attitude Scale	1.93340	0.5863

[1]Assuming Chi Square Distribution with 3 Degrees of Freedom

KRUSKAL-WALLIS ONE WAY ANALYSIS OF VARIANCE TEST RESULTS
(HIGHER SERVING-LOWER SERVING DIFFERENCES)

Variable	KW Test Stat.[1]	Level of Significance[1]	Mann Whitney Test Stat.[2]	Level of Significance[2]
Knowledge of Problems				
1. Elders in Population	0.38531	0.5332	17230	0.2666
2. Elders in Institutions	1.35368	0.2446	16642	0.1223
3. Prevalence of Mental Disorder	1.70476	0.1917	19251	0.0958
Knowledge of Policy				
4. Homemaker Service	0.87541	0.3495	16905	0.1747
5. Employment Service	0.51333	0.4737	16621	0.2369
6. Meals on Wheels	3.4999	0.0614	15923	0.0307
7. RSVP	0.14931	0.6998	18299	0.3449
8. Senior Companions	0.26080	0.6096	17366	0.3048
9. Foster Grandparents	1.12085	0.2897	16761	0.1449
10. Medicare	4.97866	0.0257	15576	0.0128
11. Medi-cal	2.22419	0.1359	16308	0.0679
12. Social Security	0.90352	0.34159	16903	0.1709
13. S.S.I.	0.88511	0.3468	16867	0.1734
14. Gold Card	2.33969	0.1261	16380	0.0631
15. Information & Referral	1.02750	0.3107	16820	0.1554
16. Tax Exemption	3.61003	0.0574	15878	0.0287
17. Law Project	9.61473	0.0019	15222	0.0010
18. Admin. on Aging	5.51093	0.0189	15566	0.0094
19. County Policy	0.04414	0.9336	17656	0.4168
20. County Policy	0.00169	0.9672	17832	0.4836
21. State Policy	0.06609	0.7971	17613	0.3986
Personal Priorities				
22. Pre-School	0.07815	0.7798	17581	0.3899
23. School Age	1.14575	0.2844	16745	0.1422
24. Adolescents	4.73140	0.0296	20188	0.0148
25. Young Adults	0.50210	0.4786	18639	0.2393
26. Mature Adults	0.01701	0.5962	18019	0.4181
27. Elders	0.67453	0.4115	17003	0.205
County Priorities				
28. Pre-School	0.12150	0.7274	18234	0.3637
29. School Age	1.11419	0.2912	16993	0.1456
30. Adolescents	8.08283	0.0045	20346	0.0022
31. Young Adults	0.45407	0.5004	17178	0.2502
32. Adults	3.48413	0.0620	15965	0.0310
33. Elders	3.08190	0.0792	16020	0.0396
Alternate Resources				
35. Psychological	0.00355	0.9525	17942	0.4763
36. Physical	0.81707	0.3660	18790	0.1830
Attitude Toward Aged				
39. Attitude Scale	1.89094	0.1691	19365	0.0845

[1] Assuming Chi Square Distribution with 1 Degree of Freedom
[2] Assuming Normal Distribution (one tail)

KRUSKAL-WALLIS ONE WAY ANALYSIS OF VARIANCE
(URBAN-RURAL DIFFERENCES)

Variable	KW Test Stat./ Level of Significance		Mann Whitney Test Stat./ Level of Significance	
Knowledge of Problem				
1. Elders in Population	2.10683	0.1466	14220	0.0733
2. Elders in Institutions	0.00154	0.9687	15385	0.4843
3. Prevelence of Mental Disorder	3.23847	0.0719	17620	0.0361
Knowledge of Policy				
4. Homemaker Service	0.13008	0.7184	15486	0.3592
5. Employment Service	1.37258	0.2414	16982	0.1207
6. Meals on Wheels	0.29265	0.5885	15307	0.2943
7. RSVP	2.29224	0.1300	17340	0.0650
8. Senior Companions	0.01934	0.9234	15933	0.4617
9. Foster Grandparents	2.80107	0.0942	17497	0.0471
10. Medicare	0.05586	0.8131	15609	0.4066
11. Medi-cal	0.15011	0.6984	15455	0.3492
12. Social Security	1.08752	0.2948	16851	0.1474
13. S.S.I.	6.68116	0.0097	18397	0.0049
14. Gold Card	0.12138	0.7275	15518	0.3638
15. Information & Referral	0.78495	0.3756	14969	0.1878
16. Tax Exemption	4.57195	0.0325	13721	0.0163
17. Law Project	1.23161	0.2671	14945	0.1335
18. Admin. on Aging	2.15447	0.1422	14479	0.0711
19. County Policy	0.06436	0.7997	15588	0.3999
20. County Policy	0.19938	0.6552	15412	0.3276
21. State Policy	1.29220	0.2556	16941	0.1278
Personal Priorities				
22. Pre-School	0.98017	0.3222	14849	0.1611
23. School Age	0.45908	0.4981	16515	0.2490
24. Adolescents	1.55714	0.2121	17007	0.1060
25. Young Adults	1.01000	0.3149	14825	0.1575
26. Mature Adults	1.31887	0.2508	16996	0.1254
27. Elders	2.47914	0.1154	14261	0.0507
County Priorities				
28. Pre-School	5.34072	0.0208	13625	0.0104
29. School Age	1.03611	0.3087	14825	0.1544
30. Adolescents	1.61326	0.2040	17038	0.1020
31. Young Adults	7.16544	0.0074	13220	0.0037
32. Adults	7.11695	0.0076	13226	0.0038
33. Elders	0.99517	0.3185	14846	0.1592
Alternate Resources				
35. Psychological	0.42385	0.5150	15207	0.2575
36. Physical	1.08011	0.2987	16827	0.1493
Attitude Toward Aged				
39. Attitude Scale	0.33171	0.5647	16426	0.2823

APPENDIX C

ANALYSIS OF VARIANCE
2-WAY INTERACTIONS
(HIGH-LOW BY URBAN-RURAL)

Variable	F Score	Level of Significance[1]
Knowledge of Problems		
1. Elders in Population	5.451	0.019
2. Elders in Institutions	0.120	0.999
3. Prevalence of Mental Disorder	5.709	0.029
Knowledge of Policy		
4. Homemaker Service	0.034	0.999
5. Employment Service	0.143	0.999
6. Meals on Wheels	0.592	0.999
7. RSVP	1.617	0.201
8. Senior Companions	1.158	0.282
9. Foster Grandparents	0.091	0.999
10. Medicare	0.000	0.999
11. Medi-cal	1.062	0.304
12. Social Security	0.112	0.999
13. S.S.I.	0.300	0.999
14. Gold Card	0.029	0.999
15. Information & Referral	1.918	0.163
16. Tax Exemption	1.829	0.173
17. Law Project	0.013	0.999
18. Admin. on Aging	0.314	0.999
19. State Policy	0.297	0.999
20. State Policy	1.212	0.271
21. Local Policy	0.172	0.999
Personal Priorities		
22. Pre-School	0.972	0.999
23. School Age	0.572	0.999
24. Adolescents	9.142	0.003
25. Young Adults	5.027	0.021
26. Mature Adults	0.268	0.999
27. Elders	0.976	0.999
County Priorities		
28. Pre-School	0.792	0.999
29. School Age	0.125	0.999
30. Adolescents	1.137	0.287
31. Young Adults	2.240	0.131
32. Adults	0.749	0.999
33. Elders	1.175	0.319
Alternate Resources		
35. Psychological	1.352	0.244
36. Physical	0.036	0.999
Attitude Toward Aged		
39. Attitude Scale	0.015	0.999

[1] With 1 Degree of Freedom

ANALYSIS OF VARIANCE
HIGH-LOW DIFFERENCES

Variable	High	Low	2 Tail Probability	T. Value
Knowledge of Problems				
1. Elders in Population	3.88	3.99	.310	-1.02
2. Elders in Institutions	3.06	3.22	.264	-1.13
3. Prevalence of Mental Disorder	2.61	2.44	.134	1.50
Knowledge of Policy				
4. Homemaker Service	2.79	2.91	.281	-1.08
5. Employment Service	2.02	1.94	.464	0.73
6. Meals on Wheels	2.94	3.15	.089	-1.71
7. RSVP	2.36	2.29	.558	0.59
8. Senior Companions	1.69	1.79	.309	-1.02
9. Foster Grandparents	2.49	2.63	.250	-1.16
10. Medicare	3.59	3.81	.019	-2.36
11. Medi-cal	3.37	3.58	.073	-1.80
12. Social Security	3.67	3.79	.163	-1.40
13. S.S.I.	3.48	3.39	.463	0.73
14. Gold Card	1.84	1.82	.100	-.156
15. Information & Referral	2.16	2.27	.37	-0.90
16. Tax Exemption	2.33	2.56	0.047	-1.99
17. Law Project	1.30	1.56	0.005	-2.82
18. Admin. on Aging	1.62	1.86	0.016	-2.44
19. County Policy	3.29	3.33	0.772	-0.29
20. County Policy	4.11	4.08	0.794	0.26
21. State Policy	4.00	4.01	0.902	-0.12
Personal Priorities				
22. Pre-School	3.71 4	3.77 4	0.774	-0.29
23. School Age	2.87 1	2.97 2	0.566	-0.57
24. Adolescents	3.01 2	2.69 1	0.064	1.86
25. Young Adults	3.55 3	3.44 3	0.483	0.70
26. Mature Adults	4.29 5	4.32 5	0.885	-0.15
27. Elders	4.53 6	4.65 6	0.493	-0.69
County Priorities				
28. Pre-School	5.13 6	5.04 6	0.559	0.58
29. School Age	3.90 4	3.70 4	0.213	1.25
30. Adolescents	3.46 3	3.10 3	0.018	2.38
31. Young Adults	2.58 2	2.63 1	0.784	-0.27
32. Adults	2.22 1	2.62 1	0.042	-2.05
33. Elders	4.56 5	4.87 5	0.050	-1.91
Alternate Resources				
35. Psychological	2.27	2.28	0.958	-0.05
36. Physical	2.26	2.17	0.300	1.04
Attitude Toward Aged				
39. Attitude Scale	7.67	7.32	0.103	1.34

ANALYSIS OF VARIANCE
URBAN-RURAL DIFFERENCES

Variable	Urban	Rural	2 Tail Probability	T. Value
Knowledge of Problems				
1. Elders in Population	3.86	4.03	0.272	-1.31
2. Elders in Institutions	3.12	3.11	0.936	0.08
3. Prevalence of Mental Disorder	2.60	2.39	0.056	1.92
Knowledge of Policy				
4. Homemaker Service	2.82	2.83	0.651	-0.45
5. Employment Service	2.02	1.86	0.143	1.47
6. Meals on Wheels	3.01	3.03	0.902	-0.12
7. RSVP	2.38	2.20	0.126	1.54
8. Senior Companions	1.72	1.72	0.969	0.04
9. Foster Grandparents	2.59	2.40	0.128	1.53
10. Medicare	3.67	3.65	0.589	0.54
11. Medi-cal	3.42	3.49	0.593	-0.53
12. Social Security	3.75	3.63	0.274	1.10
13. S.S.I.	3.55	3.21	0.013	2.51
14. Gold Card	1.69	1.71	0.837	-0.21
15. Information & Referral	2.16	2.29	0.376	-0.89
16. Tax Exemption	2.33	2.62	0.027	-2.23
17. Law Project	1.33	1.53	0.065	-1.86
18. Admin. on Aging	1.67	1.81	0.184	-1.33
19. County Policy	3.26	3.34	0.671	-0.43
20. County Policy	4.07	4.18	0.319	-1.01
21. State Policy	4.02	3.94	0.497	0.68
Personal Priorities				
22. Pre-School	3.67 4	3.80 4	0.386	-0.87
23. School Age	2.93 1	2.84 2	0.634	0.48
24. Adolescents	2.94 1	2.79 1	0.417	0.81
25. Young Adults	3.47 3	3.65 3	0.314	-1.01
26. Mature Adults	4.34 5	4.21 5	0.526	0.64
27. Elders	4.49 6	4.74 6	0.127	-1.53
County Priorities				
28. Pre-School	5.01 6	5.34 6	0.031	-2.17*
29. School Age	3.76 4	4.01 4	0.148	-1.45
30. Adolescents	3.29 3	3.28 3	0.953	0.01
31. Young Adults	2.44 2	3.00 2	0.005	- 2.81
32. Adults	2.18 1	2.81 1	0.005	-2.86
33. Elders	4.65 5	4.75 5	0.596	-0.53
Alternate Resources				
35. Psychological	2.25	2.32	0.516	-0.65
36. Physical	2.25	2.17	0.434	0.78
Attitude Toward Aged				
39. Attitude Scale	7.59	7.45	0.617	0.50

APPENDIX d

TABLES

TABLE 1

AWARENESS OF THE PROBLEMS OF ELDERS: PERCENTAGE OF CORRECT RESPONSES FROM HIGHER- AND LOWER-SERVING URBAN AND RURAL PROGRAMS (Questions 1-3)

	High-Serving	Low-Serving	Z Score
Urban	30.6	29.1	
Rural	27.0	22.8	2.623*
Total	29.8	26.8	0.705

*Statistically significant at a = .05.

TABLE 2

PERCENTAGE OF CORRECT RESPONSES ON KNOWLEDGE OF ELDERS IN THE POPULATION: HIGHER- AND LOWER-SERVING URBAN AND RURAL PROGRAM DIFFERENCES (Question 1)

	High-Serving	Low-Serving	Z Score
Urban	26.3	32.9	-1.227
Rural	27.6	12.0	1.959*
Total	26.6	25.2	

NOTE: ANOVA 2-way interaction: F score = 5.451; Kruskal-Wallis analysis of variance = 8.18064.

*Statistically significant at a = .05.

TABLE 3

PERCENTAGE OF CORRECT RESPONSES TO QUESTION ON KNOWLEDGE OF INSTITUTIONALIZATION RATE OF ELDERS: HIGH- AND LOW-SERVING URBAN AND RURAL PROGRAM DIFFERENCES

	High-Serving	Low-Serving	Z Score
Urban	29.6	27.0	
Rural	20.7	28.0	
Total	27.6	27.4	0.0088

NOTE: KW statistic 4-way interaction: 1.54571 (not significant); ANOVA 2-way interaction: F score = 0.130, not significant.

TABLE 4

PERCENTAGE OF CORRECT RESPONSES TO QUESTION ON KNOWLEDGE OF PREVALENCE OF MENTAL DISORDER IN ELDERS: HIGH- AND LOW-SERVING URBAN AND RURAL PROGRAM DIFFERENCES

	High-Serving	Low-Serving	Z Score
Urban	33.0	26.2	1.134
Rural	31.0	24.5	0.758
Total	32.8	25.6	1.475

NOTE: ANOVA 2-way interaction: F score = 5.709, significant at .05; urban-rural difference: T value = 1.92, significant at .05; high-low difference: T value = 1.50, not significant.
Kruskal-Wallis 4-way analysis: KW statistics = 8.76214, significant at .05; urban-rural difference: Mann-Whitney U = 17620, significant at .05; high-low difference: Mann-Whitney U - 19251, not significant.

TABLE 5

PERCENTAGE OF POLICY ACTORS GIVING CORRECT RESPONSES TO GENERAL AWARENESS OF PROBLEMS OF ELDERS: HIGH- AND LOW-SERVING PROGRAM DIFFERENCES

Policy Actor	High-Serving	Low-Serving	Z Score
County Administrative Officer	37.5	17.4	1.62
Mental Health Advisory Board	27.7	22.6	1.04
Mental Health Director	50.0	27.8	1.29
Program Chiefs	33.3	33.3	
Practitioners	27.9	28.4	

TABLE 6

PERCENTAGE WITH CORRECT RESPONSES ON AWARENESS OF PROBLEMS OF ELDERS IN THE COMMUNITY BY POLICY ACTORS: HIGH- AND LOW-SERVING PROGRAM DIFFERENCES (Question 1)

Policy Actor	High-Serving	Low-Serving	Z Score
County Administrative Officer	45.4	0	2.22**
Mental Health Advisory Board	22.0	24.5	-0.30
Mental Health Director	0	33.3	-1.29
Program Chiefs	36.8	20.0	1.18
Practitioners	23.7	31.4	-1.10
Total	26.5	25.1	0.2949*

*Test of significant difference between two proportions not significant.

**Significant difference at a = .05.

TABLE 7

PERCENTAGE OF POLICY ACTORS WITH CORRECT RESPONSES ON AWARENESS OF ELDERS IN INSTITUTIONS: HIGH- AND LOW-SERVING PROGRAM DIFFERENCES (Question 2)

	High-Serving	Low-Serving	Z Scale
County Administrative Officer	33.3	25.0	0.52*
Mental Health Advisory Board	25.4	28.6	0.37*
Mental Health Director	40.0	16.6	0.87*
Program Chiefs	36.8	40.0	0.21*
Practitioners	29.6	25.9	0.51*
Total	27.7	27.4	0.0688*

*Test of significant difference between two proportions: not significant.

TABLE 8

PERCENTAGE OF POLICY ACTORS WITH CORRECT RESPONSES ON AWARENESS OF PREVALENCE OF MENTAL DISORDER: HIGH- AND LOW-SERVING PROGRAM DIFFERENCES

	High-Serving	Low-Serving	Z Scale
County Administrative Officer	40.0	28.6	0.49*
Mental Health Advisory Board	35.6	14.6	2.46**
Mental Health Director	100.0	33.3	2.29**
Program Chiefs	26.3	40.0	-0.98*
Practitioners	30.4	27.8	0.35
Total	32.8	25.6	1.475*

*Test of significant difference between two proportions: not significant.

**Significant difference at a = .05.

TABLE 9

FAMILIARITY WITH STAFF POLICY BY POLICY ACTORS:
HIGH- AND LOW-SERVING PROGRAM DIFFERENCES

Policy Actors	High-Serving Programs		Low-Serving Programs		Test Statistics	
	Median	Mean	Median	Mean	Z	t
County Administrative Officers	3.86	3.64	4.00	4.00		-1.7888*
Advisory Board Members	4.24	4.11	4.12	4.00		.6212*
Mental Health Directors	4.00	5.00	4.94	4.83		.9754*
Program Chiefs	4.44	4.57	4.43	4.49		.7494
Practitioners	4.06	3.96	3.80	3.85		.6446
Total	4.26		4.23		0.2766	

Z not significant--Mann Whitney U.

*Not significant.

TABLE 10

DEGREE OF FAMILIARITY WITH COUNTY POLICY BY POLICY ACTORS:
HIGH- AND LOW-SERVING PROGRAM DIFFERENCES

	High-Serving	Low-Serving	Mann Whitney U
County Administrative Officer	3.84	3.62	
Mental Health Advisory Board	4.05	3.99	
Mental Health Director	4.60	4.50	
Program Chiefs	4.43	4.24	
Practitioners	3.83	3.72	
Total	3.95	3.92	0.2740

TABLE 11

RANK AND MEAN OF PERSONAL PRIORITY FOR MENTAL HEALTH SERVICES TO ELDERS BY ALL POLICY ACTORS: HIGH- AND LOW-SERVING URBAN AND RURAL PROGRAM DIFFERENCES

Age Group	Urban		Rural		All	
	Rank	Mean	Rank	Mean	Rank	Mean
Higher-Serving Programs						
65+, Elders	5	4.36	6	4.78	6	4.57
Lower-Serving Programs						
65+, Elders	6	5.04	6	4.61	6	4.83

NOTE: Mean and equivalent in 1 to 6 range.

TABLE 12

AVAILABILITY OF ALTERNATE SERVICES: HIGH- AND LOW-SERVING URBAN AND RURAL DIFFERENCES

	High-Serving Programs			Low-Serving Programs		
	Urban	Rural	All	Urban	Rural	All
Counseling and personal assistance	2.26	2.18	2.24	2.13	2.45	2.24
Physical support services	2.20	2.10	2.18	2.15	2.16	2.15

NOTE: Median on 5-point scale.

APPENDIX

MISCELLANEOUS QUESTIONNAIRE FINDINGS

APPENDIX

MISCELLANEOUS QUESTIONNAIRE FINDINGS

TABLE 13

AGE OF RESPONDENTS

Age Range	Total	Percent of Total
20 - 29	48	12.1
30 - 39	131	33.0
40 - 49	98	24.7
50 - 59	83	20.9
60 - 69	29	7.3
70 - 79	6	1.5
80+	2	0.5
Total	397	100.0

Median age = 41.9.

TABLE 14

PROFESSION OF RESPONDENTS

Professional Field	Number in Sample	Percent of Sample
Administration	46	11.6
Medicine	79	19.9
Psychiatric	(60)	(15.1)
Other	(19)	(4.8)
Nursing	35	8.8
Social Work	104	26.2
Psychology	58	14.6
Rehabilitation	9	2.3
Psychiatric Technician	26	6.6
L V N	1	0.0
Other	40	10.0
Total	398	100.0

TABLE 15

GERIATRIC TRAINING OF RESPONDENTS

Training	Total	Percent
No training	186	47.2
All reporting some training	208	52.8
Undergraduate	23	5.9
Professional	88	22.3
Post-graduate	81	20.6
Other	16	4.0
Total	394	100.0

TABLE 16

RELIGIOUS ORIENTATION OF RESPONDENTS

Religious Orientation	Number	Percent of Total
Protestant	233	59.7
Jewish	26	6.7
Catholic	102	26.2
Other	29	7.4
Total	390	100.0

BIBLIOGRAPHY

Baker, Frank, & Schulberg, H.C. An open systems approach to the study of mental hospitals in transition. Community Mental Health, 1969, 5, 403.

Dye, Thomas R. & Zeigler, Harmon, The irony of democracy. Belmont, Ca.: Wadsworth Co., 1970.

Katz, Daniel, & Kahn, Robert L. The social psychology of organizations. New York: John Wiley, 1966.

Weber, Mas. The theory of social and economic organization. New York: Free Press, 1947.